Hoque Medical Clinic LLC

Office Address: 407 North Coast Highway, Suite 200, Newport OR 97365
Phone Number: (541) 265-8309, Fax Number: (833) 428-3619

Patient's Name:		Patient's Birthdate		Gender:
Patient's Former or Previous Names:				
Primary Care Provider and Phone Number:		Referring Provider and Phone Number:		
Home Phone Number:	Cell Phone Number:	SSN:		Marital Status:
Email Address:		Care Home / Facility Address and Phone Number:		
Mailing Address:		City:	State:	Zip code:
Preferred Language:		Ethnicity / Race:		
Preferred Communication Method: Phone Call ___ (home phone / cellphone) Text Message ___ Email ___				
Employment Status (circle one): Full-Time Part-Time Unemployed Self-Employed Student Active Military Retired Disabled				
Employer:		Employer Address:		
Parent Guardian Information if under 18 years of age / Person consenting to treatment (Responsible Party)				
Parent/Guardian:		Date of Birth:		
Relationship to Patient:		Address if different from above:		
Insurance Information – **Please provide Insurance Card to the receptionist**				
Primary Insurance Plan Name:		Policy Holder's Name: Relationship to Patient:		
Policy Holder's Date of Birth:		Policy Holder's Employer		
Insurance ID number:		Group Number:		
Secondary Insurance Plan Name:		Policy Holder's Name: Relationship to Patient:		
Policy Holder's Date of Birth:		Policy Holder's Employer:		
Insurance ID number:		Group Number:		

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Under the Health Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI to a family member or other persons identified as involved in the patient's care or payment for the patient's healthcare. To comply with the regulations, as outlined in our facility policies, documentation of the patient's wishes must be present in the medical record.		
The following designated parties have AUTHORIZATION to my health information, written physical prescriptions, and are my emergency contacts:		
1.Primary Emergency Contact and Designated Party:	Relationship to Patient:	Phone Number:
2.Designated Party Name:	Relationship to Patient:	Phone Number:
3.Designated Party Name:	Relationship to Patient:	Phone Number:

NOTICE OF PRIVACY POLICY
I acknowledge that I have been given Hoque Medical Clinic LLC (available at front desk). I understand that if I have questions or complaints that may contact the Office Privacy Official.
Insurance Signature on File and Assignment of Benefits
I request the payment of authorized Insurance benefits be made on my behalf to Hoque Medical Clinic LLC for any services furnished to me by the clinic provider. I authorize any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim, this includes Medicare Medicaid, private insurance and other health plans.
Additional Authorizations and Acknowledgements
Authorizations for the Release of Medical Information: I consent to the treatment necessary for the patient named on this document. I authorize the release, via fax, if necessary, of all medical records, including any and all records containing HIV substance abuse and or/mental health, to the referring and family physician and to my insurance company, if applicable.
Assignment of Benefits: In consideration of any and all medical services, care, drugs, supplies furnished by Hoque Medical Clinic LLC. I hereby irrevocable transfer to Hoque Medical Clinic LLC, all insurance benefits due to payable to me and/or surgical services rendered by providers for whom Hoque Medical Clinic LLC is authorized to charge and bill. I understand and agree (regardless of insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I will also pay all costs and expenses of collection. I hereby authorize electronic billing for all of my claims.
Authorization for Review of Prescription Drug History (RX) & Formulary Information: I hereby grant permission for Hoque Medical Clinic LLC, to obtain RX history and RX formulary information from an external source. This information will provide formulary plan preferences and previous prescribed drug information from your prescription plan to aid us with your treatment plan.

Clinic Communication
Patient Portal Acknowledgement and Agreement: I have been notified that once I log in to the Hoque Medical Clinic LLC patient portal, I need to read the rules and regulations regarding the Patient Portal. I understand the dangers with online messaging between the clinic and me, and agree to the rules. I also agree to follow the rules displayed on the log in screen. I agree to follow any other instructions that the clinic may give me regarding the use of the portal. I understand messages from me to the clinic will become part of my medical chart. I agree with the information that I have been provided.
I grant permission for reminders of upcoming scheduled appointments to be left on my answering machine or with an authorized designated party, and/or sent via email, text message, or post card to your household. Notification regarding the availability of pathology, laboratory and etc results may also be left on your answering machine or with a family member who answers the telephone at your residence. Actual results however will not be left on your answering machine, though they may be communicated to those you authorized as a designated party. If you provided a cell phone number in your contact information, we will contact you on your cell phone and, if needed may leave a message (including, without limitation, email, voicemail and text message). If you choose to receive text messages, applicable carrier charges may apply.

Patient Notification of received items/acknowledgements and agreements		
□ Revised Patient Financial Policy	□ Offered HIPAA Privacy Notice	□ Received No-Show Policy

I agree that all information is correct and I have given my consent to treatment and other items by initialing those sections.

Patient, Parent or Guardian's Signature: _____ Date: _____

A copy of this signature is a valid as the original and is in effect until I revoke. I understand this form will not be updated at each but will be completed annually. I will be responsible to provide any demographic/insurance changes at time of visit.

(revised 11/2024)

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Patient Name: _____ Date of Birth: _____
Patient Address: _____
Home Phone Number: _____ Cell Phone Number: _____ Other: _____

Who is your most recent Primary Care Provider? _____
What pharmacy do you use? _____

Current Medications:

_____
_____
_____

Social History:

TOBACCO: ____Never ___ Former ____ Current ____packs per day x ____years
ALCOHOL: ____ No ____ Yes drinks per day/week _____
DRUGS USE: ____ Never ____ Former ____ Current *marijuana, methamphetamine, heroin, cocaine, ecstasy, inhalants*

Surgical History / Hospitalizations (Please list all surgeries and the year the procedures took place below)

_____
_____
_____

Have you ever had a COLONOSCOPY? ____ Yes ___ No Year Performed _____
Have you ever had an UPPER ENDOSCOPY? ____ Yes ___ No Year Performed _____

Family History: (Please list family relationship to you. Please put M for Maternal and P for Paternal)

Colon Cancer: _____ Crohn's Disease: _____ Ulcerative Colitis: _____
Celiac Disease: _____ Microscopic Colitis: _____ Collagenous Colitis: _____

Current Medical Condition/s:

_____ Diabetes _____ Hypertension _____ Hyperlipidemia
_____ Heart Disease _____ COPD _____ Kidney Disease
_____ Liver disease _____ Anxiety _____ Depression

Others:

_____
_____
_____